

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (ID)						1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																			
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)																																			
CITY						STATE						CITY						STATE																													
ZIP CODE						TELEPHONE (Include Area Code) ( )						ZIP CODE						TELEPHONE (INCLUDE AREA CODE) ( )																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																			
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY(LMP) MM DD YY						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																			
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____												22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																			
23. PRIOR AUTHORIZATION NUMBER																																															
24. A DATE(S) OF SERVICE To From MM DD YY MM DD YY						B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS		H EPSDT Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE																					
25. FEDERAL TAX I.D. NUMBER						SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$				29. AMOUNT PAID \$				30. BALANCE DUE \$																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)												33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																							
SIGNED _____												DATE _____												PIN# _____												GRP# _____											